NCPD 2.0 contact hours

Promoting Connection in the Faith Community Through Letter Writing

By Elizabeth M. Long

ABSTRACT: *Faith community nurses can reduce loneliness and provide connection for homebound members of faith communities through promotion of letter writing. Undergraduate nursing students who were matched with members of their own faith community wrote letters to older adults for 10 weeks as a community service-learning project. Data from the UCLA Loneliness Scale pre- and post-intervention showed reduced loneliness and greater connection among recipients of the letters.*

KEY WORDS: *aging, faith community nursing, letter writing, loneliness, nursing, older adults, social isolation*

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Loneliness, isolation, and lack of connection are growing public health concerns. Data suggest nearly one-fourth of adults age 65 and older are considered socially isolated and 43% of those age 60 and older report feeling lonely (National Academies of Sciences, Engineering, and Medicine [NASEM], 2020). Increased life expectancy and changing family dynamics bring unique challenges for older adults. The current life expectancy for persons in the United States as of 2022 is just over 79 years, whereas in 1950, it was slightly more than 68 years. Life expectancy predictions for the year 2050 rise to 83.37 years (Macrotrends, 2023).

Compared to past decades, older adults experience a higher divorce rate, have fewer children and siblings, and live farther geographically from their children and siblings (NASEM, 2020; National Health & Aging Trends Study, 2019). These trends suggest more older adults are living alone. Growing evidence suggests older adults' loneliness and social isolation were notably impacted by the COVID-19 pandemic (Centers for Disease Control and Prevention [CDC], 2022; Dahlberg, 2021; Power et al., 2020). In 2023, 44% of adults ages 50–80 years old reported feeling isolated in contrast to 56% during the COVID-19 pandemic (Malani et al., 2023).

Pre-pandemic survey data indicated loneliness is not limited to older adults; young adults ages 18 to 22 experienced the greatest degree of loneliness with 79%


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reporting being lonely (The CIGNA Group, 2023). Studies suggest loneliness increased among young adults during the pandemic (Malcom, 2021). The need for connection among both young and older adults remains significant.

Faith communities have a responsibility to provide connection opportunities for all members, particularly for homebound congregants. Estimates from the National Health & Aging Trends Study (2019) suggest 1.5 million older adults are homebound. There is a clear need for connection and a distinct Scriptural command to care for the needs of members in the congregation. Matthew 25:40 (NIV) tells us, "Truly I tell you, whatever you did for one of the least of these brothers and sisters of mine, you did for me." Another example was Jesus asking his disciples to care for his mother after he was gone (John 19:27). This is reinforced by Jesus' instruction: "My command is this: Love each other as I have loved you" (John 15:12-13, NIV).

LITERATURE REVIEW

The age distribution of the United States is shifting. More than 54 million adults age 65 and older in the United States account for about 16.9% of the population. The total number of adults age 65 and older is projected to increase to 85.7 million by the year 2050; at that time, the older adult population will be an estimated 22% of the overall U.S. population. Older adults are projected to outnumber children by the year 2034 (Vespa et al., 2020). About 27% of adults age 65 and older living in the community live alone (NASEM, 2020). These solitary households significantly increase in number with rising age; the Administration on Aging (2021) reported that 42% of women age 75 and older live alone. These statistics illustrate that many older adults may be without a spouse, child, or sibling nearby to rely on for care or connection and are likely members of our faith communities.

Well-documented links have been shown between physical and mental health outcomes and feelings of loneliness and social isolation in both the older and young adult populations. In older adults with loneliness or social isolation, premature mortality, functional decline, decreased quality of life, physical disability, increased falls, and cognitive decline have been reported (National Institute on Aging, 2019; Sutin et al., 2020; Werner-Seidler et al., 2017). Growing evidence suggests engagement in meaningful activities can improve quality of life and mental health and mitigate complications such as frailty (Bethell et al., 2021; Zhao et al., 2019). In younger adults, problems such as sleep disorders, weight problems, and substance use are correlated with loneliness (The CIGNA Group, 2023). Higher rates of depression, suicide, and anxiety are correlated with social isolation and loneliness in younger adults (Macalli et al., 2022). Between 2007 and 2017, drug-related deaths soared by 108% among adults ages 18 to 34, alcohol-related deaths increased by 69%, and suicides rose by 35% (Trust for America's Health, 2019). Recent data suggest young adults are twice as likely to report feeling lonely than older adults (The CIGNA Group, 2023).

Technological advances can be used to promote connection between individuals. However, a significant number of older adults are unfamiliar with technology (Hunsaker & Hargittai, 2018) or lack access. It is estimated that 22 million older adults (42%) in the United States lack broadband internet access at home (Older Adults Technology Services, 2023). Older adults may lack the confidence, skills, or the physical ability necessary to utilize technology. These disparities are significantly increased in populations of older adults who have a lower socioeconomic status, lower education levels, and who are older than 76 years (Graham, 2020; Hunsaker & Hargittai, 2018).

Limited published information exists on letter writing as an intervention to combat loneliness and promote connection. Early in the COVID-19 pandemic, during the summer of 2020, a letter writing initiative was started between baccalaureate nursing students and long-term care residents, both of whom were isolated by state and federal mandates. The project included 109 nursing student letter writers and 734 long-term care residents in southeast Texas. Students sent letters, art, and pictures to assigned residents for 10 weeks. Comments from the students and long-term care resident participants indicated feelings of connection and community through letter writing and sharing of art and other projects (Long & Knight, 2022). In another university, nursing students developed a pilot intervention to match older adults with a college student (n = 4). Specific prompts were provided, and letters were planned to be sent for 8 weeks (Miriani & Crawford, 2021). In Pennsylvania, Frank et al. (2023) completed a 12-month letter writing project with Master of Social Work students and community members utilizing anti-poverty agency services. Data suggest decreased loneliness on the UCLA Loneliness Scale at the end of the intervention.

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Sidebar. Case Study

Darla*, an 82-year-old female from a faith community involved in the study participated in the letter writing intervention. Once Darla's consent was obtained and prior to letters being sent, she completed a pre-intervention UCLA Loneliness Scale evaluation. Darla's pre-intervention scale score was 72 out of a possible 80 points, indicating a high level of loneliness.

A nursing student, who was a member of the same faith community as Darla, was assigned as Darla's letter writing partner and sent letters weekly for 10 weeks. After an introductory letter, the student also sent artwork, recipes, and other creative correspondence. With the introductory letter, the student sent a self-addressed, stamped envelope encouraging Darla to write back. Darla sent five letters to the student during the 10 weeks. After the intervention period ended, Darla again completed the UCLA Loneliness Scale. At this point, Darla's score was 24 out of a possible 80 points; she reported a significantly decreased level of loneliness. Of particular interest were four individual items within the scale. Table 1 details the questions of interest and participant responses.

Anecdotal information from a post-interview with Darla suggests a potential clinical significance to the intervention. Asked whether she enjoyed participating in the correspondence exchange, Darla responded, "Yes, I enjoyed writing the letters. It made me feel connected to someone in my church" and "I enjoyed the conversation and receiving the letters." When asked about her favorite parts of the letter writing activity, she indicated that "getting mail" and shared interests such as "faith and recipes" were highlights.

The letters provided an opportunity for intergenerational companionship (connected Darla to someone in her church), communication (getting mail), and sharing of interests (recipes and faith). The student participant reported that sending letters provided a "creative outlet during a time of stress and uncertainty" in her nursing program and was a "good way to connect with someone in her church that she would not normally communicate with."

LETTER WRITING INTERVENTION

Letter writing, unlike telephone calls or technology-based communication, has been a flexible, accessible, non-time-sensitive method to promote connection and was a common practice in the past. Thus, a letter writing intervention was instituted within a baccalaureate nursing program in a public university after obtaining Institutional Review Board approval. The intervention was initiated to evaluate the degree of loneliness within the faith communities of nursing students and to evaluate if participation in the letter writing initiative decreased levels of loneliness and promoted connection among older faith community members. This outreach was a subproject of a larger project involving letter writing to long-term care residents in 2020–2021.

For this intervention, participants were identified by a faith community leader as a homebound member who was able to comprehend and visualize the written word. Informed consent was obtained via telephone to participate in the pre-intervention, letter writing initiative, and post-intervention evaluation scale. Participants were mailed an informed consent form to sign and directed to return the signed form in the stamped envelope provided. Once the researcher received the signed consent, each participant was paired with a nursing student from the same faith community/congregation. The initiative was coordinated by a nursing faculty member who is a faith community nurse (FCN).

Students received community service-learning hours for participation in the intervention. Participation was voluntary for both the students and the faith community members. Of note, one student was fluent in written Spanish and corresponded with two members of the faith community whose primary language was Spanish.

A pre-intervention UCLA Loneliness Scale was completed on each homebound faith community participant via telephone prior to receiving letters from the assigned student. In the first week of the initiative, students sent an introductory letter to their faith community letter partner. Students continued to send letters, art, crafts, and other creative items weekly for 10 weeks. Each student was encouraged, but not required, to include a self-addressed stamped envelope if he or she wanted return correspondence with the homebound member. After the 10-weeks of correspondence, a post-intervention UCLA Loneliness Scale was completed on each faith community homebound participant.

The UCLA Loneliness Scale is a 20-item tool designed to evaluate feelings of loneliness and isolation. Since its development in 1978, two revisions took place in 1980 and 1996. Each version is considered an evidence-based reliable and valid tool for use in the older adult and younger adult population (Fetzer Institute, n.d.; Hughes et al., 2004; Lee & Cagle, 2017; Neto, 2014). Questions are listed with responses ranked from 1 to 4. A response of 1 indicates "I never feel this way" to a ranking of 4, "I often feel this way." Completed scores range from 20 to 80 with higher scores suggesting a higher degree of loneliness. Scores of 50 to 64 indicate a moderately high level of loneliness and scores of greater than 65 indicate a high level of loneliness (Neto, 2014). Version 3 of the UCLA Loneliness Scale (1996) was utilized for the letter writing intervention.

RESULTS

Seven female nursing students from seven faith communities in an urban area with homebound members ($N = 34$) participated in the intervention. All homebound participants were female. The range of ages was 78 to 86 years old. The faith communities were in southeast Texas and included Protestant and Catholic denominations. No other demographic data were

collected. A paired samples *t*-test was performed to compare loneliness scores before and after the letter writing intervention. Results demonstrated a significant decrease ($t = 0.0126099$, $p = .005$) in the level of loneliness pre-intervention ($M = 20.6$, $SD = 12$) and post-intervention ($M = 15.9$, $SD = 11.7$).

Of the 34 homebound participants, 18 corresponded with their assigned student through letter writing. (See Sidebar.) Although loneliness data were not specifically collected from the nursing students, each student submitted a final reflective journal on the experience. Themes of connection and purpose were noted. For example, one student wrote, "I connected with a church member I did not even know. In the letters, we were able to share thoughts and feelings about Bible verses that were important to us." Another student stated, "This has changed my perspective on homebound members and their needs. I am going to stay in contact with [my pen pal]; it was a joy to get mail from her." A third student reflected, "Hearing back from [my pen pal] made me feel special because I knew I was making a difference."

Nontraditional FCN Role

This project provided a nontraditional role for a trained FCN who did not have an established role within one faith community. Although nurses involved in the specialty practice faith community nursing remain relatively low in number, it is important to maintain a commitment to develop and support the strength and sustainability of the role (American Nurses Association [ANA] & Health Ministries Association [HMA], 2017; Appleton, 2021). Settings for the FCN continue to expand as needs of populations change. The *Faith Community Nursing Scope and Standards of Practice* point to faith community nursing as a specialized practice of professional nursing within the context of the faith community and the wider community (ANA & HMA, 2017). Part of the wider reach for the FCN in this project was to identify resources in the faith community among both nursing students and homebound faith community members, then partner with these subgroups to complete the project. The FCN is in a unique position to work as an advocate for the larger faith community in cultivating creative avenues to meet the needs of the population being served.

In a 2021 survey report of 1,048 FCNs, 73% reported serving a specific faith group or organization as an FCN; this suggests that 27% of FCNs are practicing in nontraditional settings (Westberg, 2022). Interestingly, one of the proposed research questions that resulted from the 2021 survey involves exploring the unique practices and focuses of FCNs (Appleton, 2021).

A survey of FCNs ($N = 378$) during the COVID-19 pandemic highlighted resilience and creativity in implementing measures to directly support their faith community as well as improve the health of the community (Shackelford et al., 2023). A nontraditional FCN role is to serve as an advocate for surrounding faith communities. This may involve leadership and collaboration. This project exemplified the role of an FCN in a wider context of community and provided an opportunity for the FCN to illustrate potential roles of faith community nursing to the faith community and nursing students involved in the project. Students participating in the project received information about opportunities to participate post-graduation in the Foundations of Faith Community Nursing Course offered at a local hospital.

Web Resources

- **Letters Against Isolation** https://www.lettersagainstisolation.com
- **Love for Our Elders** https://loveforourelders.org/letters
- **Tulip** https://www.solacecares.com/blog/letter-programs-find-write-way-to-address-loneliness/
- **Write On** https://www.writeoncampaign.com/write-to-those-in-need

Limitations

This intervention occurred during the COVID-19 pandemic, a time when many people may have had compounded feelings of loneliness and isolation. A primary limitation was the self-reported data collected on both the pre- and post-intervention scales. The collection of data within only faith communities and using all female subjects were additional limitations, restricting the ability to generalize the findings to the general older adult population. Additionally, only one participant detailed in the study participated in a post-interview with the researcher.

FAITH COMMUNITY IMPLICATIONS

Community and connection are expectations of the collective Christian faith. Biblical teachings reflect loving service to others and emphasize community. When faith communities engage in community-building activities with homebound members,

Table 1. Questions of Interest (UCLA Loneliness Scale) and Participant Response from Case Study

Item	Pre-Intervention Response	Post Intervention Response
"I lack companionship"	I often feel this way	I rarely feel this way
"My interests and ideas are not shared by those around me"	I often feel this way	I rarely feel this way
"I am unable to reach out and communicate with those around me"	I often feel this way	I never feel this way
"No one really knows me well"	I often feel this way	I never feel this way

Source: (Fetzer Institute, n.d.)

Table 2. Connection of Intervention Outcomes with Select Faith Community Nursing Scope and Standards of Practice and Competencies

Standard of Practice	Competency	Correlation to Intervention
Standard 2. Diagnosis The faith community nurse analyzes assessment data to determine actual or potential diagnoses, problems, and issues.	Identifies actual, perceived, or potential risks to the healthcare consumer's health and safety or barriers to health and wholeness, which may include but are not limited to interpersonal, systematic, cultural, spiritual, or environmental circumstances.	Identification of homebound faith community member UCLA Loneliness Scale
Standard 4. Planning The faith community nurse develops a plan that prescribes strategies to attain expected, measurable outcomes.	Identifies cost and economic implications for the healthcare consumer family, caregivers, or other affected parties and how faith community resources and local community resources may be of assistance.	Limited cost or economic implications Faith Community Resources • Coordination • Potential provision of letter writing supplies and/or stamps
Standard 13. Evidence-Based Practices and Research The faith community nurse integrates evidence and research findings into practice.	Uses current evidence-based knowledge, including research findings to guide practice. Appraises nursing research for optimal application in practice and healthcare setting.	Dissemination of data suggesting letter writing is a potential evidence-based intervention to improve loneliness in homebound faith community members More research studies are needed to build this evidence-base and apply to practice in the faith community
Standard 16. Resource Utilization The faith community nurse utilizes appropriate resources to plan, provide, and sustain evidence-based nursing services that are safe, effective, and fiscally responsible.	Assess healthcare consumer care needs and resources available to achieve desired outcomes.	Fiscally responsible intervention Easily implemented in a faith community

Note. Standards of Practice and Competencies from *Faith Community Nursing: Scope and Standards of Practice*, 2017, 3rd edition. Used with permission.

they model a biblical worldview as stated in John 15:12-13 (NIV): "My command is this: Love each other as I have loved you." Based on the participant interview statements in the case study and post-intervention responses on the loneliness scale (Table 1), there was a potential correlation between the letter writing and connection which should be investigated in further research. This low-technology intervention provided an opportunity for intergenerational connection and ministry in the faith community and served to encourage the Scriptural directive to "encourage one another and build each other up, just as in fact you are doing" (1 Thessalonians 5:11, NIV).

The FCN is an important facilitator in supporting the psychosocial health of faith community members through education and implementation of evidence-based programs to decrease loneliness and promote connection. The FCN plays a key role in identifying homebound faith community members and developing appropriate strategies to promote connection. Table 2 relays the intervention outcomes with select *Faith Community Nursing Scope and Standards of Practice and Competencies* (ANA & HMA, 2017). Although the letter writers were nursing students, this type of intervention could be adapted readily by numerous types of individuals or groups within the faith community, with the FCN coordinating and educating the community about loneliness and isolation, and methods to combat seclusion.

CONCLUSION

Loneliness is multi-faceted. Distinct dimensions of loneliness and feelings of connection need to be explored among faith community members as well as effective interventions to promote connection and decrease loneliness. The nursing students were disappointed when they did not receive responses back from their partner/member of their faith community. Future directions of the intervention may include measures to provide "writers" for participants and supplies such as stamps, so participants are assured an opportunity to respond if they wish to. Further research is needed to identify the presence and consequences of social isolation and loneliness among homebound faith community members and the potential role of the FCN. Further research also should consider the effectiveness of letter writing on the individual receiving and writing the letters. The information presented points to the potential benefits to both young and older adult faith community members with this low-technological, fiscally responsible intervention.

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